

HOSPITAL ADMINISTRATORS SURVEY COMMENTS

March 2002

Comments from 76 “Part B” of the Hospital Administrator Surveys were reviewed and grouped into the categories listed below. An attempt was made to place each comment in the appropriate category and when a comment crossed over it was included in each of the categories it pertained to. Comments were copied as is with no attempt to correct spelling and/or grammar.

Designation\Trauma Facility (44)—page 1
Emergency\Trauma Systems (30)—page 4
EMS Medical Director (8)—page 6
EMS Providers (38)—page 7
Funding (45)—page 10
Regional Advisory Councils (31)—page 13
Rural Hospitals (41)—page 15
Staffing—General (3)—page 18
Staffing—EMS (4)—page 18
Staffing—Nursing (8)—page 19
Staffing—Physicians (3)—page 19
TDH—Process Improvement (17)—page 19
TDH—Regulatory (16) —page 21
TDH—Trauma Registry (2)—page 22
Training (35)—page 22

DESIGNATION\TRAUMA FACILITY ISSUES

1. I feel that TDH should mandate for Level IV facilities to have a part time or full time trauma coordinator. We here in the Trauma Coordinators Forum from multiple trauma coordinators from Level IV facilities that they do not have enough time to truly do their trauma duties because they are not full time or part time. If you were to take a survey of the trauma facility surveyors I think that you would find this to be true.
2. RAC requirements on meeting attendance for dispo funds
3. Too many different “certification” courses requirements for physicians & nurses to satisfy trauma designation criteria. Should be one course for all!
4. Hesitancy of Level I Rehab. Centers to accept returning Texas trauma patients originally sent to Level...
5. The appearance of neurosurgeons “hiding” from trauma at the non-designated centers.
6. Trauma Centers bordering Texas state lines.
7. Lack of physician knowledge base regarding EMTALA & transfer rules
8. Trauma Centers should not be allowed to under-designate. If practicing as a Level II or III, should not be allowed to designate as a level IV.
9. Trauma Center designation should be for greater than 3 yrs before redesignation survey is required.
10. Lack of state policy/law/rules that require major/severe trauma patients go to a designated trauma center.
11. Our EMS service chooses who to send to our hospital & who not to send. We have a very capable MD staff but if EMS decides they think we don't have sufficient coverage – they will call for a helicopter & send the pt to the nearest large city. We have seen a great number of former trauma potential patients now not be transported to our hospital & get flighted out – even though we could have managed –

12. TDH needs to provide more guidance/assistance/mentoring to rural Hospitals in achieving Trauma Center Designation. The Department needs to publish a booklet or guidelines explaining, in detail, the steps required to achieve the status. The booklet should address planning for designation, the process of designation, achieving designation, maintaining designation and a list of resources available to the small hospital should a problem arise.
13. Differing opinion on definition of trauma between area hospitals and the lead facility
14. Requirements for Level II designation do not increase quality of care at this organization!
15. Costs to meet requirements for Level II are significant/excessive without any improvement in quality of care.
16. Physicians (Trauma Surgeons and Anesthesiologists) are unwilling to meet requirements for Level II without major compensation. Other physician specialties (Orthopedics, ENT, etc.) do not want additional trauma patients due to time and/or lack of reimbursement.
17. Currently we are moving toward our goal of Level II verification. Our biggest problem is that understandably physicians are requesting pay for taking call for speciality services. However by the time various speciality physicians are paid for call the cost outweighs the pt. need. I wish there was a way to compromise with both administration who looks a bottom line costs and physicians requesting monetary incentive for call coverage
18. Trauma certification needs funding support on a consistent ongoing basis – especially for small rural facilities
19. Increased RN, LVN's & MD Trauma Education: In order for the hospital to become a "Trauma Designated Facility", T.D.H. requires advanced education for staff. Not only is the educational cost an issue but, the time & distance employees must travel to complete these required courses. This is a major concern for both hospitals & staff.
20. Advanced Equipment & Monitors: How can small rural hospitals justify the expenditure on something we use so seldom? We must have this equipment in order to provide the quality of Trauma Care that our patients deserve. Where is the funds for small rural hospitals to purchase this equipment? Why is all the money going to all the bigger facilities? Are rural county people's lives not as valuable as their urban cohorts?
21. There is an expressed dissatisfaction with the planning process that the T RAC is attempting to initiate in the Valley in regards to equal sharing of the trauma load amongst tertiary care facilities in the Valley who have the same level of trauma designation. There is an unequal share of the load in regards, particularly, to neurosurgical cases. The T RAC has been unable to solve this dilemma.
22. Recently, there has been a perceived lack of support from urban, university medical centers in regards to accepting Level II and Level I trauma patients. If their systems are overloaded and they are unable to accept these patients, then there may need to be a Level II or Level I trauma facility in the Rio Grande Valley.
23. On-call physician coverage for the ED is increasingly becoming an issue with trauma surgeons, neuro-surgeons, and orthopedic surgeons. There are also recruitment issues which are especially related to rates for mal-practice insurance.
24. The dispro/trauma system tie in is the most troubling area. This should be dissolved.
25. The long range goal of having all hospital emergency Departments with a Trauma Designation is so a more standardized plan of care can be delivered to trauma patients using similar resuscitation, stabilization criteria. This desire is a great venture but unfortunately the application process for the designation is lengthy and sometime seems repetitive. The same information is requested in at least three different formats. The form ask for the hospital's role in the Trauma care in different areas that may could have been addressed once with information needed compiled. The Description of the Physicians Director's duties include two narratives, a CV, Organizational Chart, and a small Emergency Chart. The Repetition is similar in the job Description of the Trauma Director. The larger hospitals may have different personnel but in attempting to coordinate with the rural hospitals the system is managed by a smaller staff therefore our personnel for the different titles may be the same.
26. Could the hospitals that have already joined the Trauma Designation Program previously and are coming up for Redesignation have a shorter version, maybe only needing to update new information; showing new programs, equipment, certifications, etc.

27. The trauma designation process has caused an impact on EMS agencies' decisions in the treatment of their patients in the field but bypass protocols have not always been a benefit for those patients. Can the best care for a traumatically injured patient be given in the back of an ambulance instead of an ER? Sixty minutes from the scene to a hospital is a long time for a medic to be the only health caregiver involved.
28. Main problem is transferring patients to higher level of care within the two (2) hour limit
29. Problems: EMS advised to go to larger hospital in town – not a designated trauma facility – with all trauma by some surgeons.
30. Surgeons do not want trauma designation – feels it would infringe on their time and that they will be enforced to come to the hospital in a timely manner.
31. “On Call” issues are always a problem with trauma designations. Would like to see clarification on “on call.”
32. Our community is experiencing many of the subspecialties dropping hospital privileges to reduce their call obligations; examples include neurology, oral-maxillary, eye, urology, neurosurgery, spine, etc. This will cause dramatic call coverage issues for hospital emergency rooms, inpatients and follow up consults that will put Regional Trauma Centers at risk of closure. Patients will be potentially at risk and increased transfers “out” will be required. With contracting economics, HMO, PPO, reduced Medicare and Medicaid rates, very few community physicians are willing to help take care of unfunded patients. This has placed hospitals that take care of increased numbers of unfunded patients in the position of paying physicians to take call. This is not a tenable long-term solution as the cost to hospitals, particularly those already taking care of large numbers of unfunded patients and is creating a huge economic burden. Meeting the demands for payments for on-call services to cover emergency patients is negatively impacting hospitals ability to keep pace with infrastructure needs.
33. The timeliness of run sheet delivery to the receiving hospitals continues to lag behind what could be considered safe practice. This has and continues to affect patient care. The Bureau of Emergency Management has established time parameters for run sheet delivery that include the requirement that some written form of run record be left with the receiving hospital at the time the patient care delivery is given over to the hospital. This is NEVER the case with any agency utilizing electronic delivery of run records. Many agencies submit the reports at greater than twenty-four hours and then only upon request or (as in some cases) upon multiple requests. One Emergency Medical System agency contacted by our facility in attempt to retrieve a missing run record informed us it was not the practice of their agency to leave the run records at the receiving hospital and that the run sheets would not be forwarded to our facility as the information contained within was “confidential”.
34. The Emergency Medical System agencies within our region do not interface well with our hospital in accordance with our status as a General Trauma Facility. Often there is no adherence to the policies and protocols for initiating Trauma Activation status from the field. This also has and continues to affect patient care.
35. As the licensing body for Emergency Medical Service agencies and designating body for Trauma facilities, it would be expected that the Bureau of Emergency Management would begin to hold Emergency Medical Service agencies accountable by mandatory compliance with Texas Trauma System rules set forth by the Bureau itself.
36. One question that has arisen for us is transferring a patient to a higher level of care based on protocol when we could possibly care for the pt in our facility... how does this fit with EMTALA?
37. Another concern, is the possible delay in treatment for the pt when the level I facility requests all types of tests be complete before transfer. An example of this is a trauma pt with neuro involvement. We do not have neuro available at our hospital, yet the receiving facility M.D. is requesting CT scans, X-rays, multiple labs, etc and that delays transfer & care of our trauma pts. Our RAC is currently working on this issue.
38. Level 4 requirement re: Are ER nurses current in TNCC @ time of re designation. Multiple times, rural hospitals are providing this education only to have the nurse leave for another facility.
39. Suggest: Reduce the # of required certifications.

40. General surgeons are reluctant to take trauma call due to CME requirements, & time required to care for trauma patients relative to payment. Also there is fear in our institution that if we become trauma designated we will receive more non-paying patients. These issues are forcing the hospital to evaluate the need to pay physicians a stipend to participate in the trauma program. Once general surgeons are paid there is the fear of the domino effect in needing to pay all physicians to cover the ED. With lower reimbursements hospital are receiving, paying physicians may not be an option.
41. Another situation hospitals have to deal with is placement of trauma patients into rehab facilities especially if the patient has no insurance.
42. Physicians and hospitals should be offer some mechanism of payment and immunity from frivolous law suits associated with trauma.
43. Get elevation of PA's in level to facilities – many times trauma patient only seen by PA – no M.D.
44. A designative process for Pediatric Trauma Centers is needed.

EMERGENCY/TRAUMA SYSTEMS ISSUES

1. In our area with multiple small hospitals and volunteer services, the volunteer and paid services still do not bring trauma patients to the only designated trauma center in the area. They will take the patient to the closest hospital whether it is appropriate or not and then the patient is transferred which of course delays timely treatment. Yes, our RAC protocols say to take the patient to the closest most appropriate hospital, but the medical directors of the local EMS services have never gotten involved with our RAC so it is mute point.
2. We have some communities not on Biotel (sent dispatch) which causes problems.
3. A great EMS system won't last without hospitals who can care for patients. The hospitals rely on dedicated, well trained EMS staff to stabilize trauma patients in turn.
4. Recently, there has been a perceived lack of support from urban, university medical centers in regards to accepting Level II and Level I trauma patients. If their systems are overloaded and they are unable to accept these patients, then there may need to be a Level II or Level I trauma facility in the Rio Grande Valley.
5. Transfer issues are a particular problem in that transfers to a higher level of care require a ground trip of sometimes more than 5 hours of transfer time from the valley to San Antonio, Corpus Christie or Galveston.
6. There is also a perceived need for less complaining about rural facilities and their struggles by the urban, university medical centers. And, subsequently, a need for more support by these facilities.
7. The Biggest obstacle for being able to execute the Trauma Service System in an appropriate timely manner for the Basic Level IV's institutions, is the ability to gain acceptance of transfers at the higher tertiary centers. Unfortunately without the availability of CT Imaging at the small rural areas this is the need for several transfers. The traumas that involve rollovers, bicycle, four-wheeler, or falls with complaints of neck and back injuries cannot always be cleared by traditional Radiology films and must have CT to rule out and or find possible injuries. This transfer is sometime the hardest to obtain acceptance.
8. At times, unable to transfer patients we can not appropriately care for due to lack of ICU beds in larger facilities
9. Transfer to appropriate facilities.
10. There are great differences with rural based EMS agencies and those based in urban settings. Policy makers who can affect change with prehospital care are predominately urban representatives. This colors all their findings.
11. The trauma designation process has caused an impact on EMS agencies' decisions in the treatment of their patients in the field but bypass protocols have not always been a benefit for those patients. Can the best care for a traumatically injured patient be given in the back of an ambulance instead of an ER? Sixty minutes from the scene to a hospital is a long time for a medic to be the only health caregiver involved.

12. We are a four bed hospital with one ER but even our small size in case of a traumatic occurrence in San Antonio we would like to do our part in assisting other facilities. We still have a lot of patients being taken past our ER to get to another hospital down the road.
13. Main problem is transferring patients to higher level of care within the two (2) hour limit
14. Problems: EMS advised to go to larger hospital in town – not a designated trauma facility – with all trauma by some surgeons.
15. The Rio Grande Valley has challenges in regards to speciality coverage for ER patients. Specifically, neuro surgery has become the latest problem. There have been meetings with all health care providers in the Valley to resolve this, but these meetings have proved to be unproductive with finger pointing across all lines. In the meantime, patient care suffers. The political lines are deep and hard in the Valley. There are many potential and real EMTALA violations. Something must be done. At the last meeting with State folks there, they got a glimpse of how difficult the situation has become. The Physicians are the real problem. I think the EMS does a great job – They are often in the middle of this situation.
16. Though our facility is physically close to Seton Medical Center, our employees feel rather distant in terms of security. We are more likely to have “emotionally disturbed” patients who would threaten security of staff and property (whether the individual had the capacity to carry out the threat or not) Security for us is a possible “drive through” once a night. Staff have commented at how vulnerable this made them feel especially since our doors need to remain open to the public until 10:00 pm.
17. Cleveland Regional Hospital is located near the northwest boundary of Liberty Co.. We were grouped with other hospitals and EMS’s that on a normal working basis do not deal with. Our head facility in the RAC is Galveston UTMB but, in actual practice, Hermann Hospital in Houston is our main hospital.
18. A lot of the issues with EMS cannot be brought to our RAC meetings as they (EMS) are not in our RAC.
19. The rural/frontier is greatly under represented in many areas of the Texas Trauma System. We have tried to make ourselves available for the different committees to no avail. This has to change either by changing the laws or by department (BEM) rules that the rural/frontier area must be equally represented in all committees of the Texas Trauma System and GETAC as well.
20. One of the biggest issues our facility (and other local facilities) is experiencing is delays in transfers for pts needing a higher level of care. The larger facilities, including tertiary care facilities, do not have beds. While we have not had an untoward outcome, there are perceived delays in care and pts are having to wait for definitive treatment such as angioplasty.
21. One question that has arisen for us is transferring a patient to a higher level of care based on protocol when we could possibly care for the pt in our facility... how does this fit with EMTALA?
22. Another concern, is the possible delay in treatment for the pt when the level I facility requests all types of tests be complete before transfer. An example of this is a trauma pt with neuro involvement. We do not have neuro available at our hospital, yet the receiving facility M.D. is requesting CT scans, X-rays, multiple labs, etc and that delays transfer & care of our trauma pts. Our RAC is currently working on this issue.
23. Cannot always get information from Biotel in advance of a trauma arrival.
24. TSA V does not have a tertiary center that accepts trauma pts. We have 2 level IV, 6 level III (2 of the level III could be level II) but no one has stepped forward. TSAV closest II or I facility is San Antonio.
25. Transfers continue to be problematic. It took hours to find accepting tertiary facilities.
26. I spoke with Steve Janda on 10/25/01 in regards to the difficulty that we have in transferring our trauma patients. Although we have a facility 45 miles away, there are many issues which continue to stunt their comfort with accepting many trauma patients. At this time, we are air lifting the majority of our trauma to San Antonio so that we can get our pts transferred out expeditiously. I feel that The Bureau of Emergency Management is well aware of these issues and is currently working on solutions.

27. A tremendous challenge that we as a Medical Facility face, is the issue that we have a (3) town area covered by a volunteer EMS service. Not only does this service have the challenge of covering such a large area, but it has the challenge and limitations of being staffed with Basic EMT, EMT-I and only occasionally with Paramedics. Due to the inconsistencies with a volunteer service, it makes Bypass impossible at times (most often) and provides for a lack of opportunity for these providers to even develop the training and skill required to care for the trauma patients. If it would be possible for some funding to be available in these situations, I feel that it would increase the care of the pt in 2 ways: (for there to be a stable paid service). Possibly this funding could be accompanied by guidelines to further assure the quality care of the pt. such as specific certifications for the personnel and their directors. At this time there are no binding required criteria that I am aware of for physician directors of these services.
28. By providing a more stable service with more consistent and higher trained staffing which will have the ability to Bypass and/or air lift critical trauma pts to a tertiary care center when necessary.
29. Lack of Air Transport – extensive transport time
30. Appropriate field triage and equitable distribution of minor-moderately injured patients to Level III facilities.

EMS MEDICAL DIRECTOR ISSUES

1. Communications – EMS to hospital—the local EMS is staffed with only 1 paramedic – Frequently report is inadequate or not given until the ambulance is pulling into the hospital – This makes it difficult to get additional staff back in ER when needed for traumas and other critical patients. Example, a 69 y/o male with acute MI-complicated, prolonged scene time of 30 minutes trying to start an IV (which ends up being 20g or 22g), brought in Code 2 with inadequate report given while pulling into ambulance bay. This patient was critical and had to be intubated. A nurse asked them if they had not recognized how critical this patient was and got no response – I have taken previous issues like this back to their Medical Director and have gotten inadequate response. The big problem is that they frequently don't recognize how critical a patient is – Resp rates are frequently not counted & GCs are not done until later. Our hospital-based EMS is staffed with paramedics & yet the local service provides such inadequate care – I would hesitate calling the local EMS for my family.
2. There is not an EMS Medical Director in our city. He is stationed in a nearby larger town. We need to have the opportunity to provide the care.
3. Overall, our EMS is great, just need a stronger hand from Medical Director.
4. Our facility has real concerns about the oversight given EMS agencies, their staff and treatment of patients. Frequently in the rural setting we see multiple EMS agencies under the Medical Directorate of one physician. This causes medics to run on “protocols” or their judgement with little review following treatments they provide.
5. The State can not review all care rendered by EMT's in the field but there needs to be some mechanism whereby agencies are required to review the following:
 - Decision to transfer from the scene to a trauma center causing bypass of other facilities
 - Decision to intubate (or not to intubate) critical patients
 - Decision to give Rapid Sequence Intubation medications
 - Scene times greater than 20 minutes
 - Deaths at the scene or within minutes of presentation to an ER. Some information on these areas are being captured via QI screening from trauma designated facilities but there is no follow through from the EMS agencies involved or their Medical Directors.
6. There are great differences with rural based EMS agencies and those based in urban settings. Policy makers who can affect change with prehospital care are predominately urban representatives. This colors all their findings.
7. Standards & protocols. In our specific area there are five independent EMS departments. Each one has different standards and protocols, with each having a different Medical Director. This creates a need for high level of communication since we provide the only ER in the county. The Medical Director may not reside or practice in the local area increasing the disconnect with the local EMS and local hospital. Diversity. Since there are five different groups, all with different standards and skills the need and challenge to find some common ground is great.

8. A tremendous challenge that we as a Medical Facility face, is the issue that we have a (3) town area covered by a volunteer EMS service. Not only does this service have the challenge of covering such a large area, but it has the challenge and limitations of being staffed with Basic EMT, EMT-I and only occasionally with Paramedics. Due to the inconsistencies with a volunteer service, it makes Bypass impossible at times (most often) and provides for a lack of opportunity for these providers to even develop the training and skill required to care for the trauma patients. If it would be possible for some funding to be available in these situations, I feel that it would increase the care of the pt in 2 ways: (for there to be a stable paid service). Possibly this funding could be accompanied by guidelines to further assure the quality care of the pt. such as specific certifications for the personnel and their directors. At this time there are no binding required criteria that I am aware of for physician directors of these services.

EMS PROVIDER ISSUES

1. The local college does not reserve course participants for personnel seeking paramedic status to work the streets. It is designed for pre-med students which causes a lack of available EMS personnel in region.
2. Lack of accessible training to volunteer services in rural counties.
3. Lack of law requiring counties to have an EMS service available to these citizens.
4. There are so many EMS systems that it is difficult to communicate with all at one time....ie diversions.
5. In our area with multiple small hospitals and volunteer services, the volunteer and paid services still do not bring trauma patients to the only designated trauma center in the area. They will take the patient to the closest hospital whether it is appropriate or not and then the patient is transferred which of course delays timely treatment. Yes, our RAC protocols say to take the patient to the closest most appropriate hospital, but the medical directors of the local EMS services have never gotten involved with our RAC so it is mute point.
6. We need better direction for voicing complaints about EMS members or process.
7. We have a concern regarding the lack of EMS service in 1/3 of Leon County.
8. The trauma designation process has caused an impact on EMS agencies' decisions in the treatment of their patients in the field but bypass protocols have not always been a benefit for those patients. Can the best care for a traumatically injured patient be given in the back of an ambulance instead of an ER? Sixty minutes from the scene to a hospital is a long time for a medic to be the only health caregiver involved.
9. Recruitment and retention of EMS and nursing personnel: EMS, like nursing, is undergoing a shortage of personnel. Recruitment of qualified individuals to rural areas is difficult during optimal circumstances.
10. Although the RAC and the EMS entities are held accountable to the deadlines as outlined by TDH, it is not reciprocated. For example, the first installment of Tobacco funds was due to the RAC's September 1st. As of this date, no funds have been distributed, which has resulted in cancellation of an EMT course.
11. Communications – EMS to hospital: one EMS that brings patients to our hospital has about 60 miles of dead space (where no cell phone or radios will work).
12. EMS comes for transports when it is timely for them – many times we have discussions about their independence.
13. Communications – EMS to hospital—the local EMS is staffed with only 1 paramedic – Frequently report is inadequate or not given until the ambulance is pulling into the hospital – This makes it difficult to get additional staff back in ER when needed for traumas and other critical patients. Example, a 69 y/o male with acute MI-complicated, prolonged scene time of 30 minutes trying to start an IV (which ends up being 20g or 22g), brought in Code 2 with inadequate report given while pulling into ambulance bay. This patient was critical and had to be intubated. A nurse asked them if they had not recognized how critical this patient was and got no response – I have taken previous issues like this back to their Medical Director and have gotten inadequate response. The big problem is that they frequently don't recognize how critical a patient is – Resp rates are frequently not counted & GCs are not done until later. Our hospital-based EMS is staffed with paramedics & yet the local service provides such inadequate care – I would hesitate calling the local EMS for my family.
14. Our facility is small & EMS does not bring patients here.

15. Our EMS service chooses who to send to our hospital & who not to send. We have a very capable MD staff but if EMS decides they think we don't have sufficient coverage – they will call for a helicopter & send the pt to the nearest large city. We have seen a great number of former trauma potential patients now not be transported to our hospital & get flighted out – even though we could have managed –
16. The local EMS has a great working relationship with the hospital. The tobacco grants money that we get from the “J” RAC participation has allowed us to keep our EMS service upgraded to a very good level. The hospital has been very understanding in furnishing us equipment and supplies that we can not otherwise obtain.
17. We have some communities not on Biotel (sent dispatch) which causes problems.
18. Integration, cooperation a must. We need to eliminate turf wars and egos. This is all about taking care of patients, not who is going to be in control

The EMS Division of the Texas Department of Health needs to frequently provide input/information as to what the standards and requirements are for EMS in Texas. ER personnel see EMS performance, good and bad, they should be provided the standards against which they could judge the various EMS crews they encounter. Perhaps they can publish in the ENA newsletter or the BNE newsletter what should be expected from an EMS crew according to regulations.

19. Similar to the Federal Legislation that enables Hospitals to become Critical Access Hospitals, perhaps TDH could lobby for a Critical Access EMS designation. This designation could be awarded to an EMS agency who has a service area of over a certain square mileage and does not have access to a Level I trauma center within an hour of their service area. The designation would be awarded based on the above criteria as well as the EMS providing MICU level care to trauma patients. And as the federal legislation provides, these EMS agencies could be reimbursed at a higher rate for achieving this designation.
20. Failure of EMS providers to follow By Pass Protocol
21. Ambulance service to our rural community is a major problem – only one, and they are not always available to transport our patients in a timely manner. Last year, had a major trauma (MVA) during an ice storm, contacted ground ambulance who refused to drive on the roads, then called air ambulance who wasn't flying either!
22. “Overzealous” – e.g. pushing Lasix on a pt. who is less than 2 minutes from the hospital. Working a code for 50 minutes in the field when 3-5 minutes from the hospital. Not calling report until at edge of hospital property – so ED not as prepared as could be to receive the pt.
23. The State can not review all care rendered by EMT's in the field but there needs to be some mechanism whereby agencies are required to review the following:
 - Decision to transfer from the scene to a trauma center causing bypass of other facilities
 - Decision to intubate (or not to intubate) critical patients
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24. The trauma designation process has caused an impact on EMS agencies' decisions in the treatment of their patients in the field but bypass protocols have not always been a benefit for those patients. Can the best care for a traumatically injured patient be given in the back of an ambulance instead of an ER? Sixty minutes from the scene to a hospital is a long time for a medic to be the only health caregiver involved.

25. CONCERNING EMS SERVICE. Frio County EMS has four ambulances, two stationed in Pearsall, the County seat, and two in Dilley, fifteen miles south. There is paid staff covering the daytime hours, 8 a.m. to 4:30 p.m., seven days a week. After hours, there is a roster of on-call volunteers. I have been here ten years, and volunteers ebb and flow, and response from volunteers cannot be depended upon. The EMS sees their mission as responding to 911 calls, but transfers from the hospital to medical centers is viewed as a secondary goal. The EMS accepts a payment of \$30,000 per year to provide transfer services, but rarely do they respond after hours. Usually, after hours, we depend upon a private ambulance company to come from San Antonio and frequently there is a two-hour wait to transfer a patient. If the wait is too long, and the patient is too critical, an air ambulance will be called. The county does not have the money to support a full 24-hour EMS. In cities where EMS/ambulance is run by the hospital, administrators generally agree that the service is a drain on the hospital financially, and creates additional liability issues. To make matters worse, the Balanced Budget Act cut ambulance rates substantially.
26. The Rio Grande Valley has challenges in regards to speciality coverage for ER patients. Specifically, neuro surgery has become the latest problem. There have been meetings with all health care providers in the Valley to resolve this, but these meetings have proved to be unproductive with finger pointing across all lines. In the meantime, patient care suffers. The political lines are deep and hard in the Valley. There are many potential and real EMTALA violations. Something must be done. At the last meeting with State folks there, they got a glimpse of how difficult the situation has become. The Physicians are the real problem. I think the EMS does a great job – They are often in the middle of this situation.
27. Communication with EMS providers regarding care issues, patient management. Trauma systems represent continuum, but EMS not always willing to engage – or attempt to improve care.
28. EMS professional responsibility for own educational growth. I observe too many excuses rather than action. Some EMS agencies / providers are the exception to above: they should be the examples – the goals!
29. It is apparent Emergency Medical Service agencies within our region are operating independently of the rules and regulations set forth by the Texas Department of Health's Bureau of Emergency Management for the Texas Trauma System. There seem to be compliance issues within the Emergency Medical System that historically have not been effectively dealt with by the Bureau of Emergency Management.
30. The timeliness of run sheet delivery to the receiving hospitals continues to lag behind what could be considered safe practice. This has and continues to affect patient care. The Bureau of Emergency Management has established time parameters for run sheet delivery that include the requirement that some written form of run record be left with the receiving hospital at the time the patient care delivery is given over to the hospital. This is NEVER the case with any agency utilizing electronic delivery of run records. Many agencies submit the reports at greater than twenty-four hours and then only upon request or (as in some cases) upon multiple requests. One Emergency Medical System agency contacted by our facility in attempt to retrieve a missing run record informed us it was not the practice of their agency to leave the run records at the receiving hospital and that the run sheets would not be forwarded to our facility as the information contained within was "confidential".
31. The Emergency Medical System agencies within our region do not interface well with our hospital in accordance with our status as a General Trauma Facility. Often there is no adherence to the policies and protocols for initiating Trauma Activation status from the field. This also has and continues to affect patient care.
32. As the licensing body for Emergency Medical Service agencies and designating body for Trauma facilities, it would be expected that the Bureau of Emergency Management would begin to hold Emergency Medical Service agencies accountable by mandatory compliance with Texas Trauma System rules set forth by the Bureau itself.
33. We are very fortunate to work with excellent local EMS!
34. The timeliness of run sheet delivery to the receiving hospitals continues to lag behind what could be considered safe practice. This has and continues to affect patient care. The Bureau of Emergency Management has established time parameters for run sheet delivery that include the requirement that some written form of run record be left with the receiving hospital at the time the patient care delivery is given over to the hospital. This is NEVER the case with any agency utilizing electronic delivery of run records. Many agencies submit the reports at greater than twenty-four hours and then only upon request or (as in some cases) upon multiple requests. One Emergency Medical System agency contacted by our facility in attempt to retrieve a missing run record informed us it was not the practice of their agency to leave the run records at the receiving hospital and that the run sheets would not be forwarded to our facility as the information contained within was "confidential".
35. The contract EMS "encourages" patients to request Texarkana hospitals.

36. The Emergency Medical System agencies within our region do not interface well with our hospital in accordance with our status as a General Trauma Facility. Often there is no adherence to the policies and protocols for initiating Trauma Activation status from the field. This also has and continues to affect patient care.
37. As the licensing body for Emergency Medical Service agencies and designating body for Trauma facilities, it would be expected that the Bureau of Emergency Management would begin to hold Emergency Medical Service agencies accountable by mandatory compliance with Texas Trauma System rules set forth by the Bureau itself.
38. In our area with multiple small hospitals and volunteer services, the volunteer and paid services still do not bring trauma patients to the only designated trauma center in the area. They will take the patient to the closest hospital whether it is appropriate or not and then the patient is transferred which of course delays timely treatment. Yes, our RAC protocols say to take the patient to the closest most appropriate hospital, but the medical directors of the local EMS services have never gotten involved with our RAC so it is mute point.

FUNDING ISSUES

1. The number 1 issue is the legislature and state agencies finding things for us to do, however, the state can never find any money to pay for this extra work. This also applies to the Federal Government.
2. If you want things to change then provide the necessary funds to pay for making them happen.
3. The EMS/Trauma system development in our area has certainly benefited from the funds allocated by the Tobacco Settlement and SB 102. Our institution has been able to obtain equipment and training for nursing staff, EMS (which is hospital based) and first responder services in our county. However, the inconsistencies in the distribution process are very frustrating, and required reports tend to be “lost” or “misplaced” and result in repetitive measures to ensure compliance in reporting requirements.
4. Availability of funds on a consistent basis. Although we budget for quarterly installments, the funds may or may not be available.
5. Although the RAC and the EMS entities are held accountable to the deadlines as outlined by TDH, it is not reciprocated. For example, the first installment of Tobacco funds was due to the RAC’s September 1st. As of this date, no funds have been distributed, which has resulted in cancellation of an EMT course.
6. As a Trauma Level IV facility, some inservice education is provided by one of the air ambulance companies. We have been actively pursuing grants to upgrade equipment. Funds are needed to improve the emergency rooms and make them uniform with equipment and stretchers. We are still waiting on information re: the Hospital Systems Development Grant for 2001. This grant was for 3 ER stretchers and 2 Zoll Biphasic Monitor Defibrillator units with NIBP and Oximetry. We recently raised over \$200,000 in grants and private contributions to replace the antiquated x-ray machine. We would like to have access to any avenues of grant information.
7. Working with the RAC in, we will try to apply for funds (when available) to help bring speciality courses to our employees and EMS personnel as well as providers.
8. Our main concern is for the patients who come to our facility. Our needs include funds to provide state of the art equipment throughout the hospital, access to a fully staffed EMS service to provide 911 calls and transfers, and education for hospital and EMS staff.
9. Where assistance is really needed is for capital renovation projects. To make repairs, changes for more appropriate triage areas, enlarge an area, etc., is stretching already tight dollars for rural facilities beyond their capacity.
10. Staffing requirements by Medicare that RN must be in ER to do assessments
11. Indigent health care funding
 - i. Unreimbursed trauma care
 - ii. Unreimbursed out-of-county trauma transfers in to lead/tertiary trauma centers does not meet cost outlays
12. Lack of adequate funding for injury prevention activities in the state of TX. Injury/trauma is leading cause of morbidity/mortality for adults in most productive period in life (1 yr-44 yr). And efforts to decrease these numbers is not supported financially at the state or national level. Let Texas be first in the USA to demonstrate a “top-shelf” level of commitment to injury prevention.

13. Need for increased wages for nurses and paramedics
14. Who pays the cost for what ever system is developed?
15. Lack of adequate funding is one of our biggest challenges. You can't maintain an adequate trauma system is EMS services and hospitals can't stay open due to financial hardship. A great networking system is useless without providers to participate.
16. It would be nice if TDH did a better job educating the general public about EMS and the ER. Many patients abuse these two entities because they are convenient. Those patients that generally abuse these departments are also the patients who don't have the funds to pay for their visit or EMS transportation.
17. Similar to the Federal Legislation that enables Hospitals to become Critical Access Hospitals, perhaps TDH could lobby for a Critical Access EMS designation. This designation could be awarded to an EMS agency who has a service area of over a certain square mileage and does not have access to a Level I trauma center within an hour of their service area. The designation would be awarded based on the above criteria as well as the EMS providing MICU level care to trauma patients. And as the federal legislation provides, these EMS agencies could be reimbursed at a higher rate for achieving this designation.
18. Costs to meet requirements for Level II are significant/excessive without any improvement in quality of care.
19. Physicians (Trauma Surgeons and Anesthesiologists) are unwilling to meet requirements for Level II without major compensation. Other physician specialties (Orthopedics, ENT, etc.) do not want additional trauma patients due to time and/or lack of reimbursement.
20. Trauma certification needs funding support on a consistent ongoing basis – especially for small rural facilities
21. Shortage of EMT's & Paramedics: T.D.H.'s requirements are making it more difficult i.e. educational requirements to become licensed. Where is the money going to come from to cover the increasing costs? Rural communities have enough problems finding EMT's & Paramedics to work in rural areas without the added burden of changing the course curriculum.
22. Advanced Equipment & Monitors: How can small rural hospitals justify the expenditure on something we use so seldom? We must have this equipment in order to provide the quality of Trauma Care that our patients deserve. Where is the funds for small rural hospitals to purchase this equipment? Why is all the money going to all the bigger facilities? Are rural county people's lives not as valuable as their urban cohorts?
23. Unfunded mandates from any direction or department are going to be the death of rural Health Care.
24. Having the ability to pay qualified people when the larger towns receive most of the perks. The Robin Hood system seems to work for the schools.
25. The 35 mile limitation on EMS funding and ownership by CAH facilities may result in fewer EMS units being stationed in small communities. In East Texas communities are located only 10-20 miles apart. EMS services have a "presence" in most of these communities. When funding becomes too low the owners of these units will be forced to pull them back to larger community headquarters resulting in 0-no-nada coverage in those communities.
26. We need to be able to network private, for profit EMS and public, not for profit Critical Access Hospitals in such a way that the EMS owners can be assured of getting paid at least their costs.
27. The increase in indigent and uninsured patients with no reimbursement severely impacts services. Legislation mandating indigent funding at adequate levels and accessibility is necessary.

28. **CONCERNING EMS SERVICE.** Frio County EMS has four ambulances, two stationed in Pearsall, the County seat, and two in Dilley, fifteen miles south. There is paid staff covering the daytime hours, 8 a.m. to 4:30 p.m., seven days a week. After hours, there is a roster of on-call volunteers. I have been here ten years, and volunteers ebb and flow, and response from volunteers cannot be depended upon. The EMS sees their mission as responding to 911 calls, but transfers from the hospital to medical centers is viewed as a secondary goal. The EMS accepts a payment of \$30,000 per year to provide transfer services, but rarely do they respond after hours. Usually, after hours, we depend upon a private ambulance company to come from San Antonio and frequently there is a two-hour wait to transfer a patient. If the wait is too long, and the patient is too critical, an air ambulance will be called. The county does not have the money to support a full 24-hour EMS. In cities where EMS/ambulance is run by the hospital, administrators generally agree that the service is a drain on the hospital financially, and creates additional liability issues. To make matters worse, the Balanced Budget Act cut ambulance rates substantially.
29. Medicaid and Medicare insurance carriers continue to reject claims, or reduce payments, for what is interpreted after the fact to be non-emergency visits. This practice should have stopped with the Prudent Lay Person legislation. This has placed hospitals and emergency physicians in a horrible financial bind, as the patient who presents for example with "chest pain" and is found not to have cardiac disease is retrospectively deemed non-emergent. This however occurs after the resources to rule out cardiac disease have been expended.
30. Statewide Emergency Physicians working in hospital, which take care of large numbers of unfunded patients, are being reimbursed at low rates per patient, as hospitals cannot afford to make up the difference. This is resulting in migration of some of the experienced providers to financially more rewarding hospitals and decreasing the quality of care of Emergency Medicine hospitals caring for the unfunded. The decreased reimbursement is coming at the same time malpractice insurance rates are rising in a dramatic fashion for this specialty. Further, with lack of specialty back up and issue in many hospitals the malpractice risk for the patient and physician is rising.
31. The lack of a healthcare financing district to support indigent care is also causing funding issues. The healthcare providers that bear a substantial load of indigent patients are suffering more severely than those who do not.
32. In our community, a city entity retained millions of dollars of Tobacco Settlement money for general use. These funds should have been 100% directed to the hospital facilities caring for these patients.
33. Dollars. Each county is supporting and in some cases, the county is supporting several different EMS groups with varying dollars of support. Assumption is that combining the dollars, structure, standards and educational requirements would provide the citizens on the communities a higher quality of emergent care than is currently being seen.
34. I have been involved in the development of the Texas Trauma System for nine years. It was my understanding that the main reason was to improve trauma care, reduce trauma death rates, increase public education on injury prevention, and to assist the rural/frontier volunteer EMS systems. This did happen to a certain extent until money came into the picture. The formula distribution of money was not well received by the city/urban folk, ever considering what it would do to the rural/frontier EMS systems. As it stands our EMS laws do not have enough Teeth to mandate a city or a county to provide money for an EMS System. Laws need to change or department rules (BEM) so that a city or county can combine their money to fully support an EMS system in a rural/frontier area. The future of the volunteer EMS entities are dwindling by leaps and bounds. Please help!
35. Major problems with trauma systems are: A. Funding for major traumas without insurance. Being the highest trauma level in a region increases cost and causes problems with physician specialist willing to be available on call. B. Major traumas increase liability exposure to healthcare providers. C. The cost is significant to maintain physician and staff for trauma. Solutions: Increase funding for facilities designated for trauma.
36. Reimbursement for Lead Trauma Facilities: There are a number of requirements/expectations that contribute to high costs for lead facilities that are not adequately funded. High indigent populations (36% of our trauma patients) already place a strain on the institution.
37. Non-funded RAC Mandates: As trauma systems grow and face increasing requirements from the state, there are very limited resources for system development. An example would be disaster management, which requires significant financial outlay for communication and decontamination equipment, as well as other resources and supplies, but is poorly funded if at all.
38. Limited and Diminishing Rural EMS Resources: Access to pre hospital care is tenuous at best in many rural (not to mention frontier) areas. The cost of providing pre hospital care is rapidly leading to cessation of many services. Rural hospitals also have difficulty arranging transportation for all patients, not just trauma, to tertiary care. The system will fail if we do not have the front-line resources to get the patients into it.
39. Funding/reimbursement for uninsured patients.

40. Reimbursement for operating a helicopter service is generally bad debt or the “cost of doing business.”
41. A tremendous challenge that we as a Medical Facility face, is the issue that we have a (3) town area covered by a volunteer EMS service. Not only does this service have the challenge of covering such a large area, but it has the challenge and limitations of being staffed with Basic EMT, EMT-I and only occasionally with Paramedics. Due to the inconsistencies with a volunteer service, it makes Bypass impossible at times (most often) and provides for a lack of opportunity for these providers to even develop the training and skill required to care for the trauma patients. If it would be possible for some funding to be available in these situations, I feel that it would increase the care of the pt in 2 ways: (for there to be a stable paid service). Possibly this funding could be accompanied by guidelines to further assure the quality care of the pt. such as specific certifications for the personnel and their directors. At this time there are no binding required criteria that I am aware of for physician directors of these services.
42. Uncompensated Trauma Care is an issue that must be addressed.
43. Equipment – grant \$ available for high dollar trauma equipment – Level 1 Bld Warmer, etc.
44. EMS system operates only at Intermediate level, no MICY or paramedic capabilities. Lack of funds, personnel available to up date services.
45. Mandatory regulations/staff training set by state but no funding assistance. Small rural hospitals financially burdened as is, difficult if not impossible sometimes to meet regulations.

REGIONAL ADVISORY COUNCIL (RAC) ISSUES

1. It is my hope that you might still consider the concerns expressed here. We have been giving this much thought and are now ready to set those thoughts on paper. Communication: Our primary concern is the lack of communication between hospital administrators and the RAC administrator. Many in the RAC have felt for some time that the RAC administrator has not been doing his job, however, very little (if anything) has been done to correct the situation (i.e., insist on accountability in his job duties, counseling, firing the RAC administrator, and replacement of the RAC administrator, etc). Instead, work was begun a short time ago on development of a “new” RAC. It seems to me that instead of developing a “new” RAC we would be better served by fixing the problems in the current RAC. My concerns have been voiced through the RAC hierarchy to no avail.
2. There are so many EMS systems that it is difficult to communicate with all at one time...ie diversions.
3. We need better direction for voicing complaints about EMS members or process.
4. DFW Hosp. Council & North Tex RAC are trying to improve communications but they are not working together.
5. In our area with multiple small hospitals and volunteer services, the volunteer and paid services still do not bring trauma patients to the only designated trauma center in the area. They will take the patient to the closest hospital whether it is appropriate or not and then the patient is transferred which of course delays timely treatment. Yes, our RAC protocols say to take the patient to the closest most appropriate hospital, but the medical directors of the local EMS services have never gotten involved with our RAC so it is mute point.
6. The EMS/Trauma system development in our area has certainly benefited from the funds allocated by the Tobacco Settlement and SB 102. Our institution has been able to obtain equipment and training for nursing staff, EMS (which is hospital based) and first responder services in our county. However, the inconsistencies in the distribution process are very frustrating, and required reports tend to be “lost” or “misplaced” and result in repetitive measures to ensure compliance in reporting requirements.
7. Availability of funds on a consistent basis. Although we budget for quarterly installments, the funds may or may not be available.
8. Although the RAC and the EMS entities are held accountable to the deadlines as outlined by TDH, it is not reciprocated. For example, the first installment of Tobacco funds was due to the RAC’s September 1st. As of this date, no funds have been distributed, which has resulted in cancellation of an EMT course.
9. Working with the RAC in, we will try to apply for funds (when available) to help bring speciality courses to our employees and EMS personnel as well as providers.

10. RAC requirements on meeting attendance for dispro funds
11. Distance required to attend RAC meetings
12. Distance required for educational opportunities
13. Our EMS service chooses who to send to our hospital & who not to send. We have a very capable MD staff but if EMS decides they think we don't have sufficient coverage – they will call for a helicopter & send the pt to the nearest large city. We have seen a great number of former trauma potential patients now not be transported to our hospital & get flighted out – even though we could have managed –
14. The local EMS has a great working relationship with the hospital. The tobacco grants money that we get from the “J” RAC participation has allowed us to keep our EMS service upgraded to a very good level. The hospital has been very understanding in furnishing us equipment and supplies that we can not otherwise obtain.
15. Integration, cooperation a must. We need to eliminate turf wars and egos. This is all about taking care of patients, not who is going to be in control
16. Share the decisions, share the responsibility and share the money. Provide equal board representation.
17. Failure of EMS providers to follow By Pass Protocol
18. The RAC is dominated by the special interests of one medical center in East Texas.
19. There is an expressed dissatisfaction with the planning process that the T RAC is attempting to initiate in the valley in regards to equal sharing of the trauma load amongst tertiary care facilities in the valley who have the same level of trauma designation. There is an unequal share of the load in regards, particularly, to neurosurgical cases. The T RAC has been unable to solve this dilemma.
20. We have to travel over 100 miles to go to classes like PALS/ACLS. The hospital pays for the class but not the travel.
21. The RAC is a good program for networking and discussing similar or new problems. The educational opportunity from this is a great advantage for the rural hospitals always needing avenues for further learning with a limited budget.
22. The State can not review all care rendered by EMT's in the field but there needs to be some mechanism whereby agencies are required to review the following:
 - Decision to transfer from the scene to a trauma center causing bypass of other facilities
 - Decision to intubate (or not to intubate) critical patients
 - Decision to give Rapid Sequence Intubation medications
 - Scene times greater than 20 minutes
 - Deaths at the scene or within minutes of presentation to an ER
23. Education and equipment upgrades continue to be vital. Keep up the good work offering grants directly to hospitals, EMS units and RAC's to upgrade these areas. Don't send it all to the RAC's. There is still too much politics in the RAC's so that some get more than others although the need is reversed. The RAC's are working hard to work together but the nature of the beast leads to politics over ruling reason – As is true with most State run initiatives.
24. The Emergency Medical System agencies within our region do not interface well with our hospital in accordance with our status as a General Trauma Facility. Often there is no adherence to the policies and protocols for initiating Trauma Activation status from the field. This also has and continues to affect patient care.
25. Another concern, is the possible delay in treatment for the pt when the level I facility requests all types of tests be complete before transfer. An example of this is a trauma pt with neuro involvement. We do not have neuro available at our hospital, yet the receiving facility M.D. is requesting CT scans, X-rays, multiple labs, etc and that delays transfer & care of our trauma pts. Our RAC is currently working on this issue.

26. Since the inception of our RAC (8+ years ago), there has been a lack of information shared with all RAC facilities, as well as a lack of involvement/communication. This has been shared with the State's Bureau of Emergency Management Staff, both in person while doing their RAC "assessments" in 2000, as well as in the past. The response has been less-than-assistive. If there is an intent for full participation, some type of accountability system is needed with an objective analysis & action at The State level. I can't believe The State staff have been objective, rather subjective in their response without understanding the inner workings of The RAC & community.
27. RAC Authority: The RAC develops and implements a regional plan based solely on the good will of the participants. "Non-players" have the ability to sabotage the plan in many ways – keeping patients inappropriately, transferring non-critical injuries to the trauma center on weekends, sending patients to non-designated centers. There is no mechanism to give teeth to the guidelines that are developed, particularly if disproportionate share funding is not an issue for the offending organization.
28. Non-funded RAC Mandates: As trauma systems grow and face increasing requirements from the state, there are very limited resources for system development. An example would be disaster management, which requires significant financial outlay for communication and decontamination equipment, as well as other resources and supplies, but is poorly funded if at all.
29. More emphasis on EMS Education related to training personnel to transport trauma to the nearest designated trauma facility.
30. More ER Physician supported training – ie. Trauma Protocols/Criteria for Transport/Guidelines for Workups.
31. Difficult to keep staff (nursing) certified in ACLS, PALS, TNCC, EPNC due to financial hardship of facility and locations where offered usually over 100 miles away.

RURAL HOSPITAL ISSUES

1. Small hospitals are routinely in a "crunch", most run on a "skeleton" crew, esp. at night. Having to run a simultaneous Trauma Code & a Dr. Heart is impossible. So, staffing is a major concern...
2. Another area of concern is staffing. The rural hospitals have one person designated as the Trauma Coordinator, BUT that person might also be the Infection Control Nurse, the Risk Manager, the Utilization Review Person, etc. Other rural hospitals combine the positions of Medical Staff Coordinator / Hospital Wide QI Coordinator / Infection Control Nurse / Risk Manager / Worker's Compensation Nurse / and Trauma Registrar..... Well, you get the picture – the list goes on and on and on and on. Rural hospitals cannot afford to hire one person as a Trauma Coordinator.
3. State "Surveys": People who work in rural hospitals in management positions are usually EXTREMELY organized individuals. They are able to accomplish all the tasks involved in these multiple positions because they ARE so well organized. At least two to three times a year the "someone from the state" will issue a "survey" for hospital personnel to complete. Invariably the survey asks for information that must be researched instead of pulled up in pre-existing reports. Trauma surveys are no exception. Our request is that you tell us twelve (12) months in advance of when you want to receive data results so that we can work that additional data set into our pre-existing process. It is a waste of time to go back through records an auditor has already audited to glean new data that is time sensitive. This process is not only time consuming it is EXPENSIVE to pay staff to do double work.
4. TDH Policies and Regulations: You mentioned regulations – all we ask is that you keep in mind the rural areas and when you establish new policies and regulations. We are not Austin, Dallas, or Houston. We do not have resources we can draw on to pay for implementing new regulations and policies are passed. Some of our patients are 60-90 miles away from a RURAL hospital and the rural hospitals provide a necessary source of care for the region. When we must expend money to implement new policies &/or procedures mandated by TDH that process takes away resources from our patients. Thank you for your time.
5. In our area with multiple small hospitals and volunteer services, the volunteer and paid services still do not bring trauma patients to the only designated trauma center in the area. They will take the patient to the closest hospital whether it is appropriate or not and then the patient is transferred which of course delays timely treatment. Yes, our RAC protocols say to take the patient to the closest most appropriate hospital, but the medical directors of the local EMS services have never gotten involved with our RAC so it is mute point.
6. Nursing staffing is a huge problem. There is not always available a secondary nurse. Hospitals are not always able to provide nursing staff. There is so much cost containment for hospitals that is difficult to get money for staffing.

7. Recruitment and retention of EMS and nursing personnel: EMS, like nursing, is undergoing a shortage of personnel. Recruitment of qualified individuals to rural areas is difficult during optimal circumstances.
8. Currently, there is difficulty with the staffing of the local EMS during the daytime hours. More and more, TDH certified employees of the hospital are having to make transfers to out of town hospitals and/or backup for the unit going out of town. An employee of the hospital is an EMS Educator, L.P., and member of the local EMS., and has suggested that administration research the feasibility of the Hospital assuming the EMS at some point in time if agreeable with the County government. The Hospital employs approximately 7 people who hold TDH certificates ranging from Basic EMT to Licensed Paramedic.
9. As a Trauma Level IV facility, some inservice education is provided by one of the air ambulance companies. We have been actively pursuing grants to upgrade equipment. Funds are needed to improve the emergency rooms and make them uniform with equipment and stretchers. We are still waiting on information re: the Hospital Systems Development Grant for 2001. This grant was for 3 ER stretchers and 2 Zoll Biphasic Monitor Defibrillator units with NIBP and Oximetry. We recently raised over \$200,000 in grants and private contributions to replace the antiquated x-ray machine. We would like to have access to any avenues of grant information.
10. Our main concern is for the patients who come to our facility. Our needs include funds to provide state of the art equipment throughout the hospital, access to a fully staffed EMS service to provide 911 calls and transfers, and education for hospital and EMS staff.
11. Where assistance is really needed is for capital renovation projects. To make repairs, changes for more appropriate triage areas, enlarge an area, etc., is stretching already tight dollars for rural facilities beyond their capacity.
12. Distance required to attend RAC meetings
13. Distance required for educational opportunities
14. Communications – EMS to hospital: one EMS that brings patients to our hospital has about 60 miles of dead space (where no cell phone or radios will work).
15. Communications – EMS to hospital—the local EMS is staffed with only 1 paramedic – Frequently report is inadequate or not given until the ambulance is pulling into the hospital – This makes it difficult to get additional staff back in ER when needed for traumas and other critical patients. Example, a 69 y/o male with acute MI-complicated, prolonged scene time of 30 minutes trying to start an IV (which ends up being 20g or 22g), brought in Code 2 with inadequate report given while pulling into ambulance bay. This patient was critical and had to be intubated. A nurse asked them if they had not recognized how critical this patient was and got no response – I have taken previous issues like this back to their Medical Director and have gotten inadequate response. The big problem is that they frequently don't recognize how critical a patient is – Resp rates are frequently not counted & GCs are not done until later. Our hospital-based EMS is staffed with paramedics & yet the local service provides such inadequate care – I would hesitate calling the local EMS for my family.
16. Our facility is small & EMS does not bring patients here.
17. There is not an EMS Medical Director in our city. He is stationed in a nearby larger town. We need to have the opportunity to provide the care.
18. Additionally, EMS comes for transports when it is timely for them – many times we have discussions about their independence.
19. TDH needs to provide more guidance/assistance/mentoring to rural Hospitals in achieving Trauma Center Designation. The Department needs to publish a booklet or guidelines explaining, in detail, the steps required to achieve the status. The booklet should address planning for designation, the process of designation, achieving designation, maintaining designation and a list of resources available to the small hospital should a problem arise.
20. Ambulance service to our rural community is a major problem – only one, and they are not always available to transport our patients in a timely manner. Last year, had a major trauma (MVA) during an ice storm, contacted ground ambulance who refused to drive on the roads, then called air ambulance who wasn't flying either!
21. Trauma certification needs funding support on a consistent ongoing basis – especially for small rural facilities.

22. Advanced Equipment & Monitors: How can small rural hospitals justify the expenditure on something we use so seldom? We must have this equipment in order to provide the quality of Trauma Care that our patients deserve. Where is the funds for small rural hospitals to purchase this equipment? Why is all the money going to all the bigger facilities? Are rural county people's lives not as valuable as their urban cohorts?
23. Rural Hospitals are not going to be able to keep their doors open if the larger facilities receive most of the State and/or Federal financial assistance.
24. Rural Hospitals are being neglected, and eventually something has to give.
25. There is a perceived need for more support for rural healthcare from government agencies including more guidance and problem-solving approaches rather than just coming to the valley multiple times for discussion about the problems. The problems are well identified by those here in the valley. There is a need for some guidance towards needed changes.
26. There is also a perceived need for less complaining about rural facilities and their struggles by the urban, university medical centers. And, subsequently, a need for more support by these facilities.
27. Education @ our institution is non-existent. We have to travel over 100 miles to go to classes like PALS/ACLS. The hospital pays for the class but not the travel
28. There is very little education offered for hospital staff.
29. Unfunded mandates from any direction or department are going to be the death of rural Health Care.
30. Having the ability to pay qualified people when the larger towns receive most of the perks. The Robin Hood system seems to work for the schools.
31. The RAC is a good program for networking and discussing similar or new problems. The educational opportunity from this is a great advantage for the rural hospitals always needing avenues for further learning with a limited budget.
32. The Biggest obstacle for being able to execute the Trauma Service System in an appropriate timely manner for the Basic Level IV's institutions, is the ability to gain acceptance of transfers at the higher tertiary centers. Unfortunately without the availability of CT Imaging at the small rural areas this is the need for several transfers. The traumas that involve rollovers, bicycle, four-wheeler, or falls with complaints of neck and back injuries cannot always be cleared by traditional Radiology films and must have CT to rule out and or find possible injuries. This transfer is sometime the hardest to obtain acceptance.
33. At times, unable to transfer patients we can not appropriately care for due to lack of ICU beds in larger facilities
34. Transfer to appropriate facilities.
35. Our facility has real concerns about the oversight given EMS agencies, their staff and treatment of patients. Frequently in the rural setting we see multiple EMS agencies under the Medical Directorate of one physician. This causes medics to run on "protocols" or their judgement with little review following treatments they provide.
36. We are a four bed hospital with one ER but even our small size in case of a traumatic occurrence in San Antonio we would like to do our part in assisting other facilities. We still have a lot of patients being taken past our ER to get to another hospital down the road.

37. **CONCERNING EMS SERVICE.** Frio County EMS has four ambulances, two stationed in Pearsall, the County seat, and two in Dilley, fifteen miles south. There is paid staff covering the daytime hours, 8 a.m. to 4:30 p.m., seven days a week. After hours, there is a roster of on-call volunteers. I have been here ten years, and volunteers ebb and flow, and response from volunteers cannot be depended upon. The EMS sees their mission as responding to 911 calls, but transfers from the hospital to medical centers is viewed as a secondary goal. The EMS accepts a payment of \$30,000 per year to provide transfer services, but rarely do they respond after hours. Usually, after hours, we depend upon a private ambulance company to come from San Antonio and frequently there is a two-hour wait to transfer a patient. If the wait is too long, and the patient is too critical, an air ambulance will be called. The county does not have the money to support a full 24-hour EMS. In cities where EMS/ambulance is run by the hospital, administrators generally agree that the service is a drain on the hospital financially, and creates additional liability issues. To make matters worse, the Balanced Budget Act cut ambulance rates substantially.
38. **Limited and Diminishing Rural EMS Resources:** Access to pre hospital care is tenuous at best in many rural (not to mention frontier) areas. The cost of providing pre hospital care is rapidly leading to cessation of many services. Rural hospitals also have difficulty arranging transportation for all patients, not just trauma, to tertiary care. The system will fail if we do not have the front-line resources to get the patients into it.
39. A tremendous challenge that we as a Medical Facility face, is the issue that we have a (3) town area covered by a volunteer EMS service. Not only does this service have the challenge of covering such a large area, but it has the challenge and limitations of being staffed with Basic EMT, EMT-I and only occasionally with Paramedics. Due to the inconsistencies with a volunteer service, it makes Bypass impossible at times (most often) and provides for a lack of opportunity for these providers to even develop the training and skill required to care for the trauma patients. If it would be possible for some funding to be available in these situations, I feel that it would increase the care of the pt in 2 ways: (for there to be a stable paid service). Possibly this funding could be accompanied by guidelines to further assure the quality care of the pt. such as specific certifications for the personnel and their directors. At this time there are no binding required criteria that I am aware of for physician directors of these services.
40. Our hospital is very small 16 beds in a town with 2 EMS capable facilities. Our agreement with 911 is that we do not receive any trauma as our M.D.'s; arcy, lab, anesthesia, or personnel are on call. The other two facilities are Medical Centers with full capability to care for most patients in the community. If a patient comes to our facility - (it is not marked as a Hospital or ER). We initiate 911 if the patient is beyond our capability.
41. EMS system operates only at Intermediate level, no MICY or paramedic capabilities. Lack of funds, personnel available to up date services.

STAFFING ISSUES: GENERAL

1. "Small hospitals are routinely in a "crunch", most run on a "skeleton" crew, esp. at night. Having to run a simultaneous Trauma Code & a Dr. Heart is impossible. So, staffing is a major concern...."
2. Another area of concern is staffing. The rural hospitals have one person designated at the Trauma Coordinator, BUT that person might also be the Infection Control Nurse, the Risk Manager, the Utilization Review Person, etc. Other rural hospitals combine the positions of Medical Staff Coordinator / Hospital Wide QI Coordinator / Infection Control Nurse / Risk Manager / Worker's Compensation Nurse / and Trauma Registrar..... Well, you get the picture – the list goes on and on and on and on. Rural hospitals cannot afford to hire one person as a Trauma Coordinator.
3. Not enough staff in the ED to handle to patient volumes and acuity.

STAFFING ISSUES: EMS

1. Recruitment and retention of EMS and nursing personnel: EMS, like nursing, is undergoing a shortage of personnel. Recruitment of qualified individuals to rural areas is difficult during optimal circumstances.
2. Currently, there is difficulty with the staffing of the local EMS during the daytime hours. More and more, TDH certified employees of the hospital are having to make transfers to out of town hospitals and/or backup for the unit going out of town. An employee of the hospital is an EMS Educator, L.P., and member of the local EMS., and has suggested that administration research the feasibility of the Hospital assuming the EMS at some point in time if agreeable with the County government. The Hospital employs approximately 7 people who hold TDH certificates ranging from Basic EMT to Licensed Paramedic.

3. Shortage of EMT's & Paramedics: T.D.H.'s requirements are making it more difficult i.e. educational requirements to become licensed. Where is the money going to come from to cover the increasing costs? Rural communities have enough problems finding EMT's & Paramedics to work in rural areas without the added burden of changing the course curriculum.
4. Lack of paramedics in Colorado County – delays in transfers at times.

STAFFING ISSUES: NURSING

1. Another area of concern is staffing. The rural hospitals have one person designated at the Trauma Coordinator, BUT that person might also be the Infection Control Nurse, the Risk Manager, the Utilization Review Person, etc. Other rural hospitals combine the positions of Medical Staff Coordinator / Hospital Wide QI Coordinator / Infection Control Nurse / Risk Manager / Worker's Compensation Nurse / and Trauma Registrar..... Well, you get the picture – the list goes on and on and on and on. Rural hospitals cannot afford to hire one person as a Trauma Coordinator
2. Nursing staffing is a huge problem. There is not always available a secondary nurse. Hospitals are not always able to provide nursing staff. There is so much cost containment for hospitals that is difficult to get money for staffing.
3. Recruitment and retention of EMS and nursing personnel: EMS, like nursing, is undergoing a shortage of personnel. Recruitment of qualified individuals to rural areas is difficult during optimal circumstances.
4. Staffing requirements by Medicare that RN must be in ER to do assessments
5. Nursing Shortage = \$\$\$ = Retention
6. Lack of qualified nurses to fill open positions
7. TDH needs to become an advocate for a “bridge course” to nursing from other allied health professions. Respiratory therapy, Paramedic, Pharmacy technician, etc... are all courses that could be “bridged” to RN with some effort. These allied health technicians should not be allowed to “challenge” the nursing boards, however, with an appropriate program they should be able to cross over to nursing. This will also help in the nursing shortage.
8. We are able to attract and retain nurses and other staff. We have an excellent group of emergency medicine physicians under contract. We are about to begin a major building expansion to approximately double our Emergency Department space.

STAFFING ISSUES: PHYSICIANS

1. Critical shortage of neurosurgery care for trauma outside the often overloaded lead facilities.
2. There are also recruitment issues which are especially related to rates for mal-practice insurance.
3. Our biggest problem is with specialty on-call capabilities. We have only 4 out of 7 nights/week for orthopedic coverage. We are working to recruit more orthopods's, but this remains a problem. Perhaps we are fortunate, as other hospitals nearby are experiencing shortages in other specialties.

TDH: PROCESS IMPROVEMENT RECOMMENDATIONS

1. The local project grants that have helped rural EMS for so many years is becoming so difficult to fill out that the detail and administrative hurdles prevent some of us from applying. Please simplify these forms.
2. Although the RAC and the EMS entities are held accountable to the deadlines as outlined by TDH, it is not reciprocated. For example, the first installment of Tobacco funds was due to the RAC's September 1st. As of this date, no funds have been distributed, which has resulted in cancellation of an EMT course.
3. TDH needs to provide more guidance/assistance/mentoring to rural Hospitals in achieving Trauma Center Designation. The Department needs to publish a booklet or guidelines explaining, in detail, the steps required to achieve the status. The booklet should address planning for designation, the process of designation, achieving designation, maintaining designation and a list of resources available to the small hospital should a problem arise.

4. The EMS Division of the Texas Department of Health needs to frequently provide input/information as to what the standards and requirements are for EMS in Texas. ER personnel see EMS performance, good and bad, they should be provided the standards against which they could judge the various EMS crews they encounter. Perhaps they can publish in the ENA newsletter or the BNE newsletter what should be expected from an EMS crew according to regulations.
5. TDH needs to become an advocate for a “bridge course” to nursing from other allied health professions. Respiratory therapy, Paramedic, Pharmacy technician, etc... are all courses that could be “bridged” to RN with some effort. These allied health technicians should not be allowed to “challenge” the nursing boards, however, with an appropriate program they should be able to cross over to nursing. This will also help in the nursing shortage.
6. It would be nice if TDH did a better job educating the general public about EMS and the ER. Many patients abuse these two entities because they are convenient. Those patients that generally abuse these departments are also the patients who don't have the funds to pay for their visit or EMS transportation. Perhaps TDH could adopt the stance that EMS and ER's have “emergency” in their name for a reason. It would be especially helpful if the Department could stress that an ER must screen every patient but is not required to treat a patient if the condition isn't life threatening. Many people have the misconception that an ER must treat everybody that walks through the door, TDH could help dispel the myth and encourage the use of alternate facilities for routine health care of minor emergencies.
7. Similar to the Federal Legislation that enables Hospitals to become Critical Access Hospitals, perhaps TDH could lobby for a Critical Access EMS designation. This designation could be awarded to an EMS agency who has a service area of over a certain square mileage and does not have access to a Level I trauma center within an hour of their service area. The designation would be awarded based on the above criteria as well as the EMS providing MICU level care to trauma patients. And as the federal legislation provides, these EMS agencies could be reimbursed at a higher rate for achieving this designation.
8. Requirements for Level II designation do not increase quality of care at this organization!
9. Local Project Grants: What happened to these funds? We thought this project would help set off some of the expenditures. We have never received any of these funds even though we have made proposal grants for the last 3 years.
10. Lack of adequate staff (in numbers) at the TDH Bureau of Emerg. Management (the job salaries are too low to recruit.)
11. There is a perceived need for more support for rural healthcare from government agencies including more guidance and problem-solving approaches rather than just coming to the valley multiple times for discussion about the problems. The problems are well identified by those here in the valley. There is a need for some guidance towards needed changes.
12. ...unfortunately the application process for the designation is lengthy and sometime seems repetitive. The same information is requested in at least three different formats. The form ask for the hospital's role in the Trauma care in different areas that may could have been addressed once with information needed compiled. The Description of the Physicians Director's duties include two narratives, a CV, Organizational Chart, and a small Emergency Chart. The Repetition is similar in the job Description of the Trauma Director. The larger hospitals may have different personnel but in attempting to coordinate with the rural hospitals the system is managed by a smaller staff therefore our personnel for the different titles may be the same.
13. Could the hospitals that have already joined the Trauma Designation Program previously and are coming up for Redesignation have a shorter version, maybe only needing to update new information; showing new programs, equipment, certifications, etc.
14. Education and equipment upgrades continue to be vital. Keep up the good work offering grants directly to hospitals, EMS units and RAC's to upgrade these areas. Don't send it all to the RAC's. There is still to much politics in the RAC's so that some get more than others although the need is reversed. The RAC's are working hard to work together but the nature of the beast leads to politics over ruling reason – As is true with most State run initiatives.
15. “On Call” issues are always a problem with trauma designations. Would like to see clarification on “on call.”
16. I have serious concerns that the recent increase in required classroom hours for paramedics will damage immediately and, probably eliminate eventually, rural EMS departments, especially those vital independent volunteer services. *My concerns to Austin have gone totally not addressed.*

17. Since the inception of our RAC (8+ years ago), there has been a lack of information shared with all RAC facilities, as well as a lack of involvement/communication. This has been shared with the State's Bureau of Emergency Management Staff, both in person while doing their RAC "assessments" in 2000, as well as in the past. The response has been less-than-assertive. *If there is an intent for full participation, some type of accountability system is needed with an objective analysis & action at The State level.* I can't believe The State staff have been objective, rather subjective in their response without understanding the inner workings of The RAC & community.

TDH: REGULATORY ISSUES

1. "TDH not holding EMS services as accountable to the trauma system as they do the hospitals."
2. "Mandatory QI for EMS as part of licensure by TDH."
3. "Survey" EMS providers as thoroughly as hospitals.
4. State "Surveys": People who work in rural hospitals in management positions are usually EXTREMELY organized individuals. They are able to accomplish all the tasks involved in these multiple positions because they ARE so well organized. At least two to three times a year the "someone from the state" will issue a "survey" for hospital personnel to complete. Invariably the survey asks for information that must be researched instead of pulled up in pre-existing reports. Trauma surveys are no exception. Our request is that you tell us twelve (12) months in advance of when you want to receive data results so that we can work that additional data set into our pre-existing process. It is a waste of time to go back through records an auditor has already audited to glean new data that is time sensitive. This process is not only time consuming it is EXPENSIVE to pay staff to do double work.
5. TDH Policies and Regulations: You mentioned regulations – all we ask is that you keep in mind the rural areas and when you establish new policies and regulations. We are not Austin, Dallas, or Houston. We do not have resources we can draw on to pay for implementing new regulations and policies are passed. Some of our patients are 60-90 miles away from a RURAL hospital and the rural hospitals provide a necessary source of care for the region. When we must expend money to implement new policies &/or procedures mandated by TDH that process takes away resources from our patients. Thank you for your time.
6. We need better direction for voicing complaints about EMS members or process.
7. I feel that TDH should mandate for Level IV facilities to have a part time or full time trauma coordinator. We here in the Trauma Coordinators Forum from multiple trauma coordinators from Level IV facilities that they do not have enough time to truly do their trauma duties because they are not full time or part time. If you were to take a survey of the trauma facility surveyors I think that you would find this to be true
8. Lack of state policy/law/rules that require major/severe trauma patients go to a designated trauma center.
9. Overall, as a nurse, I have a problem with "not documented, not done!" There are truly times when this is next to impossible to do – rather than decrease paperwork for nurses, regulatory bodies keep increasing it!
10. Rules such as MOT's and being slapped with large fines is yet another paper chase that seems to have a higher priority than providing safe, quality patient care.
11. This is the first for profit hospital I've worked for & certainly the last. Administration has an attitude of staying under budget. They have no care in world about the quality of care patients are receiving. Budget allows for no improvement. With the new HIPPA regs we need a lot of improvement. I can guarantee that no improvement will happen unless surveyed by CMS. They know what needs to be done but will not act as long as they can get away with it. I don't like being surveyed by CMS, but I think this hospital needs to be watched closely. I would be in favor of a monthly survey by CMS. – It's that bad! For profit hospitals are interested in one thing, & one thing only – MONEY!!! – Who cares if the patient died, which if the proper equipment was ordered the patient would have lived, - their concern is, "Did we make money off of them?" It's so bad I'm changing professions. I am scared by the images of care that I have seen here. Patient's have died because of decisions made by people wearing suits!

12. The State can not review all care rendered by EMT's in the field but there needs to be some mechanism whereby agencies are required to review the following:
 - Decision to transfer from the scene to a trauma center causing bypass of other facilities
 - Decision to intubate (or not to intubate) critical patients
 - Decision to give Rapid Sequence Intubation medications
 - Scene times greater than 20 minutes
 - Deaths at the scene or within minutes of presentation to an ER
13. It is apparent Emergency Medical Service agencies within our region are operating independently of the rules and regulations set forth by the Texas Department of Health's Bureau of Emergency Management for the Texas Trauma System. There seem to be compliance issues within the Emergency Medical System that historically have not been effectively dealt with by the Bureau of Emergency Management.
13. Our facility has on two occasions filed formal complaints on two separate Emergency Medical System agencies with the Bureau of Emergency Management but have received no follow-up to date. The Emergency Medical System agencies should be required by the Bureau of Emergency Management to monitor their compliance with the Bureau's own rules.
14. As the licensing body for Emergency Medical Service agencies and designating body for Trauma facilities, it would be expected that the Bureau of Emergency Management would begin to hold Emergency Medical Service agencies accountable by mandatory compliance with Texas Trauma System rules set forth by the Bureau itself.
15. Cleveland Regional Hospital is located near the northwest boundary of Liberty Co. *We were grouped with other hospitals and EMS's that on a normal working basis do not deal with.* Our head facility in the RAC is Galveston UTMB but, in actual practice, Hermann Hospital in Houston is our main hospital.
16. Of great concern are the continuing education requirements for EMS personnel. In the rural areas, it is an extreme hardship to travel to acquire the tremendous number of required hours. First of all, there is an insufficient number of qualified EMS personnel to cover the community needs when other personnel are out of town pursuing CE credits. Secondly, the number of CE hours required for EMS personnel is out of line. For instance, a basic EMT must have 40 hours every two years---- that is twice as many as a LVN or RN. *Something must be done to reduce the required number of CE credits.* An alternative to this is to increase initial training time for EMS personnel at every level. Currently, an EMT-B class includes 144 classroom hours and 48 clinical hours. Consideration should be given to increasing clinical hours to 88 for an EMT-B, 216 clinical hours for an EMT-I, and 400 clinical hours for a EMT-P.

TDH: TRAUMA REGISTRY ISSUES

1. Trauma registry continues to be an issue for our area. We utilize a regional registry and upload to TDH regularly, which is a requirement to be eligible for funds. However, once the information is uploaded, it seems to fall into a black hole. Frequently we are asked to re-submit data. I recognize the expectation is for the TRAC-IT program is to resolve this issue.
2. Trauma registry very time consuming

TRAINING ISSUES

1. No Haz Mat support for mass casualty. Currently no knowledge of EMS decontamination procedures in the field.
2. The local college does not reserve course participants for personnel seeking paramedic status to work the streets. It is designed for pre-med students which causes a lack of available EMS personnel in region.
3. Lack of accessible training to volunteer services in rural counties.
4. The EMS/Trauma system development in our area has certainly benefited from the funds allocated by the Tobacco Settlement and SB 102. Our institution has been able to obtain equipment and training for nursing staff, EMS (which is hospital based) and first responder services in our county. However, the inconsistencies in the distribution process are very frustrating, and required reports tend to be "lost" or "misplaced" and result in repetitive measures to ensure compliance in reporting requirements.

5. As a Trauma Level IV facility, some inservice education is provided by one of the air ambulance companies. We have been actively pursuing grants to upgrade equipment. Funds are needed to improve the emergency rooms and make them uniform with equipment and stretchers. We are still waiting on information re: the Hospital Systems Development Grant for 2001. This grant was for 3 ER stretchers and 2 Zoll Biphasic Monitor Defibrillator units with NIBP and Oximetry. We recently raised over \$200,000 in grants and private contributions to replace the antiquated x-ray machine. We would like to have access to any avenues of grant information.
6. Working with the RAC in, we will try to apply for funds (when available) to help bring speciality courses to our employees and EMS personnel as well as providers.
7. Communications – EMS to hospital—the local EMS is staffed with only 1 paramedic – Frequently report is inadequate or not given until the ambulance is pulling into the hospital – This makes it difficult to get additional staff back in ER when needed for traumas and other critical patients. Example, a 69 y/o male with acute MI-complicated, prolonged scene time of 30 minutes trying to start an IV (which ends up being 20g or 22g), brought in Code 2 with inadequate report given while pulling into ambulance bay. This patient was critical and had to be intubated. A nurse asked them if they had not recognized how critical this patient was and got no response – I have taken previous issues like this back to their Medical Director and have gotten inadequate response. The big problem is that they frequently don't recognize how critical a patient is – Resp rates are frequently not counted & GCs are not done until later. Our hospital-based EMS is staffed with paramedics & yet the local service provides such inadequate care – I would hesitate calling the local EMS for my family.
8. Lack of physician knowledge base regarding EMTALA & transfer rules
9. General lack of preparedness to biological/chemical/terroristic warfare.
10. Lack of qualified nurses to fill open positions
11. RAC-T needs assistance with ACLS, ATLS, PALS, TNCC. We have personnel wanting to recertify & not enough classes to attend & we have personnel wanting to become instructors with Instructor Courses not available (preferably within driving distances).
12. A great EMS system won't last without hospitals who can care for patients. The hospitals rely on dedicated, well trained EMS staff to stabilize trauma patients in turn.
13. Increased RN, LVN's & MD Trauma Education: In order for the hospital to become a "Trauma Designated Facility", T.D.H. requires advanced education for staff. Not only is the educational cost an issue but, the time & distance employees must travel to complete these required courses. This is a major concern for both hospitals & staff.
14. A definite lack of trauma related training and educational opportunities here in the Rio Grande Valley. We have not had a TNCC since December of 1999. We have no instructors in the valley who are updated and there is tremendous difficulty in securing TNCC instructors from other places in Texas to come to the valley to teach TNCC. There are similar issues with other necessary courses for both nurses and EMS providers.
15. Education @ our institution is non-existent. We have to travel over 100 miles to go to classes like PALS/ACLS. The hospital pays for the class but not the travel
16. There is very little education offered for hospital staff.
17. The RAC is a good program for networking and discussing similar or new problems. The educational opportunity from this is a great advantage for the rural hospitals always needing avenues for further learning with a limited budget.
18. Difficulty with meeting needs of mental health patients.
19. Education and equipment upgrades continue to be vital.

20. REGARDING EDUCATIONAL SERVICES. The Texas Organization of Rural and Community Hospital (TORCH), through its subsidiary, Texas Rural Health Telecommunications Alliance, using federal grants, has developed a private network, currently with 57 rural hospitals enrolled. This network has a major goal to provide educational opportunities through their high-speed Internet network. There is the opportunity to save travel expense and reduce tuition expense by providing education in-house through Internet and video conferencing. Several hospitals have used these federal grants for teleconferencing, and we plan to develop this capacity with the next round of grants, in 2002. Recently, we re-certified our nurses and several doctors for ACLS, by renting a computer with a built-in program for one month. The PC had a built-in CD that was purchased for \$6,000, which is approved by the American Heart Association. We have advised the TRHT Alliance of the educational tool, and they are working to purchase the program and put it on the Alliance network. This is much cheaper than sending people off, and paying for a hotel and travel expenses. There is, of course, expense for utilizing the educational programs. If you would like to learn more about this network, you may call Debra Miner at E-Health Solutions at (281) 494-6644.
21. We are taking steps to improve our Bio/Chemical Terrorism capabilities. Making progress on that.
22. Training. Each EMS group has different education and hiring standards. Some of the groups have highly skilled paid staff, others have very basic, volunteers all increasing the possibility of erroneous assumptions and the need for increased communication.
23. Insuring appropriate training in assessing and treating children.
24. I have serious concerns that the recent increase in required classroom hours for paramedics will damage immediately and, probably eliminate eventually, rural EMS departments, especially those vital independent volunteer services. My concerns to Austin have gone totally not addressed
25. We would like more info on educational grants as well as more classes offered to Rural areas – Many nurses feel they cannot afford the extra classes & our hospital is low on \$ to help out.
26. Of great concern are the continuing education requirements for EMS personnel. In the rural areas, it is an extreme hardship to travel to acquire the tremendous number of required hours. First of all, there is an insufficient number of qualified EMS personnel to cover the community needs when other personnel are out of town pursuing CE credits. Secondly, the number of CE hours required for EMS personnel is out of line. For instance, a basic EMT must have 40 hours every two years---- that is twice as many as a LVN or RN. Something must be done to reduce the required number of CE credits. An alternative to this is to increase initial training time for EMS personnel at every level. Currently, an EMT-B class includes 144 classroom hours and 48 clinical hours. Consideration should be given to increasing clinical hours to 88 for an EMT-B, 216 clinical hours for an EMT-I, and 400 clinical hours for a EMT-P.
27. In case of a citywide disaster – “bio terrorism” proportion cross credentialing, supplies, communication, media & mental issues needs to be addressed.
28. More emphasis on EMS Education related to training personnel to transport trauma to the nearest designated trauma facility.
29. Accessibility to bio-terrorism training – 0 cost – will be willing to assist in conference coordination.
30. More critical-thinking based education for both EMS & Nursing – ie. Interpretation of data/symptoms & appropriate protocol implementation.
31. More ER Physician supported training – ie. Trauma Protocols/Criteria for Transport/Guidelines for Workups.
32. Difficult to keep staff (nursing) certified in ACLS, PALS, TNCC, EPNC due to financial hard ship of facility and locations where offered usually over 100 miles away.
33. Hospitals not where prepared for chemical/biological disasters. Funding not available for training, equipment etc...
34. General lack of preparedness to biological/chemical/terroristic warfare.
35. Lack of adequate funding for injury prevention activities in the state of TX. Injury/trauma is leading cause of morbidity/mortality for adults in most productive period in life (1 yr-44 yr). And efforts to decrease these numbers is not supported financially at the state or national level. Let Texas be first in the USA to demonstrate a “top-shelf” level of commitment to injury prevention.